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Why Washington state's health reform faltered after loss of mandates

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As the U.S. Supreme Court tackles the question of whether individuals can be required to buy health insurance — a key provision in the federal health-care overhaul — some in Washington state are battling a strong sense of déjà vu mixed with dread.

They remember 1993, when state lawmakers passed a comprehensive state law aimed at insuring everyone and spreading the health-care expenses of the sickest throughout a large pool of policyholders.

But the law, which relied on both mandates and incentives, was soon dismembered, leaving only popular provisions, such as prohibiting insurers from denying coverage to sick people or making them wait many months for coverage.

Without any leverage to bring healthy people onto insurance rolls, insurers, left with the priciest patients, began a financial death spiral.

Ultimately, companies pulled out of the individual market and almost no one in Washington could buy an individual policy for any price.

For those involved, the lessons learned remain sharp as a scalpel.

"It's the same thing we're very likely to face if the Supreme Court blows a hole in the current law," warns Randy Revelle, a former King County executive who was heavily involved in the state effort nearly two decades ago.

Unlike the debate going on in the high court, the lessons here don't involve constitutional questions. They're all about the realities of the health-insurance market and politics.

At the top of the list:

Lesson 1: Good intentions, no matter how popular, can backfire — big time.

Lesson 2: A machine doesn't work so well if you remove parts.

Lesson 3: Buy-in from both political parties and strong public support are needed to maintain enough momentum to sustain complex reforms through potential changes in administration.

The '94 "death spiral"

In an amicus brief in the Supreme Court case, Gov. Chris Gregoire and other governors referred to the "death spiral" in Washington's individual-insurance market that began in 1994.

The 1993 law, passed when Democrats controlled both houses and the governor's seat, was then the most ambitious overhaul effort in the nation.

The delicate balancing act ended when Republicans, who objected to what they saw as heavy-handed government control of the health industry, swept into power in both houses.

By the time the new Legislature finished, the only parts of the law that survived were the "consumer-friendly" pieces, championed by then-Insurance Commissioner Deborah Senn, a Democrat.

"We kept some of the insurance reforms in law, because they were very popular, but we didn't keep the market reforms," says Pam MacEwan, who was a member of the Health Services Commission charged with implementing the law and is now a Group Health Cooperative executive. "It was a big problem."

That's primarily because there was nothing left in the law to push or entice people to buy insurance when they were healthy, which would have spread costs more broadly.

What happened next is starkly summarized in a 1995 letter sent to Premera Blue Cross by a woman in Eastern Washington.

A few months before she gave birth that year, the woman bought an individual policy from Premera. As soon as the insurer paid her hospital expenses, the woman canceled the policy, telling Premera "we will do business with you again when we are pregnant."

True to her word, in 1996, she bought insurance, Premera said, once again canceling after the insurer paid for the delivery of her next child.

Altogether, she paid in $1,807 in premiums. Premera paid out $7,024.68 in medical bills.

You don't have to be a business genius to recognize the problem with those numbers when multiplied by thousands of customers.

Claims went up. Premiums rose. Pretty soon only sick people thought insurance was worth the cost. Premiums rose even more.

Healthy people, like the Eastern Washington woman, waited until they needed insurance to buy it. At the time, Gov. Gary Locke likened it to buying fire insurance after your house is on fire.

State breaks the logjam

Before deciding in 1998 not to sell any more individual policies in the state, Premera lost $120 million in today's dollars, says company spokesman Eric Earling. By mid-1999, the state's other two big insurers, Regence BlueShield and Group Health, stopped selling individual policies.

In 1999, with the individual health-insurance market essentially dead, Locke began crafting a compromise. Signed into law in the spring of 2000, it was a bitter pill for some, but it got the market back into action.

In exchange for coming back into the market, insurers could charge whatever they wanted, bypassing the rate review normally done by the insurance commissioner's office. They could also force patients to wait nine months to be covered, and exclude the most expensive patients.

To deal with those patients, the state revived its high-risk pool. Insurers, who would help subsidize the pool, would be allowed to reject 8 percent of applicants, who could then buy coverage through the pool — if they could afford it.

At the time, Sen. Alex Deccio, a Republican from Yakima, summed it up neatly: "We are in a private-enterprise system."

"Have" vs. "have-not"

Washington's insurance experience, some worry, could be repeated on a much larger scale, should the Supreme Court find the mandate unconstitutional.

Insurers, in an amicus brief to the court, argue that if the mandate is removed they should be allowed to exclude people and set prices based on health — now barred in the federal plan.

Others argue that the mandate, with its relatively weak financial penalty for those who don't buy insurance, isn't necessary for the federal health overhaul to proceed.

They calculate that many young, low-income uninsured would buy policies without a mandate, since the federal overhaul dangles attractively low premiums for the young and subsidizes those with low incomes.

State Sen. Karen Keiser, D-Kent, who chairs the Senate's health-care committee and a group of lawmakers exploring alternatives, says if the federal mandate is overturned, each state would be left to choose options ranging from doing nothing to legislating ways to bring as many people as possible into a health-insurance pool.

"Of course, that would mean that our country would be made of 'have' states and 'have-not' states, making the health disparities even worse, which is pretty awful," Keiser said in an email.

Washington Insurance Commissioner Mike Kreidler says 85 percent of state residents, who now have group coverage, wouldn't be directly affected by the federal mandate.

But, he adds, the typical Washington family's yearly insurance bill includes about $1,000 to cover costs for the uninsured, which his office calculates have reached about $1 billion a year in the state. The state hospital association says charges for charity care and bad debt by patients may amount to as much as $2 billion.

Kreidler's office has estimated that under the federal plan, the vast majority of the approximately 1 million uninsured would qualify for Medicaid or subsidies.

Revelle, now policy leader for the Washington State Hospital Association, says the state's struggle to improve health coverage was illuminating.

"A fundamental lesson we learned in the process — and that unfortunately was not learned in the federal process — is that health care is so big, so complex, so passionate, that it has got to have bipartisan support," Revelle said.

It also needs widespread public support to last through the years it takes to impose changes on an entrenched industry.

And that's difficult, he says, not only because of health care's complexity, but because people do not agree on fundamental values.

"It's very hard to look out five or 10 years," Revelle says. "But we should constantly be thinking: Where do we need to be five to 10 years from now?"